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Testimony before the Public Health Committee
in support of Raised Bill 425

by Jane McNichol, Executive Director
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I am Jane McNichol, Executive Director of the Legal Assistance Resource Center of Connecticut, the advocacy and support center for legal services programs in the state. We represent the interests of very-low income residents of the state.

I am here to express strong **support for RB 425, An Act Concerning a Basic Health Program**.

The state Basic Health Program (SBHP) would provide affordable and good quality health care coverage for 75,000 low-income adults not covered by Medicaid in 2014. The SBHP would be funded by the federal government.

If carefully designed, the SBHP could also cover HUSKY parents with incomes over 133% of the federal poverty level, an additional 15,000-20,000 people, and save the state about $50 million.

The state Basic Health Program: An important option under the Affordable Care Act.

The state Basic Health Program (SBHP) is an option under the federal Affordable Care Act. It is designed to provide a mechanism for high-cost states such as Connecticut to provide affordable health care to adults with incomes between 133% and 200% of the federal poverty level. For a single person, this means someone with income between $14,856 and $22,340. For a family of four, this is a family with income between $30,657 and $46,100.

The state Basic Health Program can be affordable; the Health Insurance Exchange, even with subsidies, will not be.

This Basic Health Program option was included in the federal Affordable Care Act because of concern that the cost of participation in the Exchange, even with subsidies, would be prohibitive to low-income residents of high-cost states like Connecticut. The Mercer report to the Health Insurance Exchange Board confirms this concern for Connecticut. Mercer estimates that of the 74,000 adults eligible for the Exchange or a state Basic Health Program, only 37,500 (50%) would access health insurance through the Exchange while 51,000 (70%) would enter the state Basic Health Program.

Even people who opt for insurance in the Exchange will be "underinsured". Underinsurance is defined as lacking financial protection from medical expenses. Research suggests that, for people with incomes below 200% fpl, being at risk of spending more than 5% of income on medical expenses constitutes underinsurance.* Estimates of expenses in the Exchange, even when reduced by subsidies, indicate that most participants would be underinsured.

Estimated Out of Pocket Spending in Connecticut's Exchange for 2014

Single Person Household (100% FPL = $11,170)	
Low Health Burden: 8% of income	
138% FPL = $1,233	200% FPL = $1,787
Medium Health Burden: 11% of income	
138% FPL = $1,696	200% FPL = $2,457
High Health Burden: 13% of income	
138% FPL = $2,004	200% FPL = $2,904

Four Person Household (100% FPL = $23,050)	
Low Health Burden: 8% of income	
138% FPL = $2545	200% FPL = $3688
Medium Health Burden: 11% of income	
138% FPL = $3499	200% FPL = $5071
High Health Burden: 13% of income	
138% FPL = $4135	200% FPL = $5993

Percentage of income for low, medium and high health burden households from Mercer Report (table 41-2, p. 226). Multiplied by 2012 Federal Poverty Level dollar amounts to estimate out of pocket spending (dollar amounts will likely be higher in 2014 due to inflation)

Figures for estimated costs on the Exchange available from the Kaiser Family Foundation Subsidy Calculator, available at www.kff.org suggest the possibility of much higher costs for families with significant health needs.

In Connecticut, we have already recognized this problem. We provide health care in Medicaid HUSKY A for parents up to 185% of the federal poverty level, with no cost-sharing, because we recognize that cost-sharing will make health care coverage unaffordable for these parents.

In its research for the Health Insurance Exchange, Mercer modeled three designs for a state Basic Health Program. In each design, cost-sharing requirements fell below 5% of income.

2014 Connecticut Exchange and Basic Health Models with Total Medical Cost Exposure*

Connecticut SBHP Options				
FPL	Exchange	Medicaid model	Option 1 (low cost)	Option 2 (high cost)
138%	$75 (5%)	$0 (0%)	$20 (1%)	$35 (2%)
150%	$90 (6%)	$0 (0%)	$20 (1%)	$35 (2%)
200%	$200 (10%)	$0 (0%)	$40 (2%)	$100 (5%)

Monthly medical cost exposure (premiums + average cost-sharing) are shown, with share of household income in parenthesis. Data taken from the Connecticut Mercer report.

Federal funding will be available for the state Basic Health Program.

The state Basic Health Program would be run by the state and funded by the federal government. If the state establishes a Basic Health Program, people eligible for the SBHP would not be eligible for subsidies in the Health Insurance Exchanges that will operate in 2014. Instead, the state would receive the federal funds that would otherwise be used for subsidies in the Exchange for adults with incomes between 133% and 200% fpl. This federal funding would be used to fund the state Basic Health Program.

In each of the programs Mercer modeled, including the one in which the benefits and cost-sharing mirrored the state's Medicaid program, Mercer found that the federal subsidies likely to be available to the state would pay for the cost of the SBHP with some surplus funding. (Any surplus funding is required by federal law to be spent on the SBHP.)

The state Basic Health Program should mirror Medicaid.

Within certain limits set by the federal government, the state would design the SBHP, including establishing the benefits package and cost-sharing requirements. The bill envisions, and we strongly support, a SBHP with benefits, cost-sharing and administrative procedures that mirror Connecticut's Medicaid program. Such a program would offer a variety of advantages to the state and the individuals in the SBHP:

- Medicaid offers the comprehensive benefit package that people at this income level need and will not be able to afford in the Exchange. Importantly, Medicaid offers dental and coordinated behavioral health coverage and assistance in accessing transportation.
- There will be more continuity of care if provider networks and benefits are the same as Medicaid. Studies indicate that within one year, the incomes of about 50% of adults with incomes below 200% fpl will shift between eligibility for Medicaid and eligibility for the SBHP (or the Exchange in the absence of a SBHP). A SBHP which mirrors Medicaid will allow for seamless transfers from Medicaid to the SBHP and back when necessary.
- Adults with children in HUSKY will be in the same network as their children. Studies show that more children are covered by health insurance when their parents are covered.
- If the program mirrors Medicaid, HUSKY parents with incomes between 133% and 185% fpl, who are currently covered by Medicaid, could be covered in this program with no loss of benefits or increase in cost-sharing. **The state would save about $50 million in state Medicaid costs while continuing Medicaid-like coverage for 15,000 – 20,000 HUSKY adults.**

The state Basic Health Program should be decided on and planned this year, when the state is designing its Health Insurance Exchange.*

Planning for the Exchange and for a state Basic Health Program should proceed in tandem. The Mercer Report indicates that the inclusion of the population that would be eligible for a SBHP in the Exchange would affect both the risk in the Exchange and mechanisms for achieving sustainability in the Exchange.

The number of expected enrollees in plans in the Exchange will most likely affect the staffing, budget and administrative assessments in the Exchange.

Individuals with incomes between 133% and 200% fpl may differ from other possible Exchange participants in their health status, geographic location, level of education and expertise in using the health care system. The Exchange and health plans in the Exchange will need to design services differently to meet different needs depending on who is in the Exchange. Specifically, the Exchange would have to tailor the following services to the expected Exchange population:

- The system for rating health plans and the quality measures chosen to ensure plans provide appropriate support services;

- Outreach efforts to encourage eligible individuals to enroll using trusted intermediaries in the geographic areas where they live;
- Educational and marketing materials in multiple languages at appropriate literacy and health-literacy levels;
- Call center that supports appropriate volume of calls and appropriate languages;
- Billing and collections services.

Insurers that anticipate offering health plans through the Exchange will also make different decisions depending on whether people with incomes between 138% and 200% fpl are included in the Exchange. Health plans calculate premiums based on a number of factors including the expected number of enrollees, geographic area, age, family status, and health status; all of these factors will be affected by whether lower-income individuals are enrolled in a SBHP or in the Exchange. If this population is included in the Exchange, health plans will need to develop or expand certain targeted services, such as care coordination and clinical care management.

For all these reasons, it is important that the legislature act to adopt a state Basic Health Program this session so that the Exchange planning can proceed based on realistic assumptions.

RB 425 proposes an appropriate planning process for the state Basic Health Program.

RB 425 proposes a planning process for the SBHP which takes into account two competing concerns:

- Connecticut needs to make decisions about the SBHP this year as it plans its Health Insurance Exchange.
- The federal and state governments have not yet made certain decisions which will affect the amount of federal funding available for the SBHP.

To deal with the need to make a decision and the short legislative timeline this year, the bill proposes that the state opt for a SBHP designed to be cost-neutral to the state, require the Office of Health Reform and Innovation to design the SBHP and then incorporate legislative review of the SBHP design through a process similar to the federal waiver review process. Under this plan, key committees concerned with the SBHP would have the opportunity to review and approve, reject or modify the plan prepared by the Office of Health Reform and Innovation.

Other key provisions of RB 425:

- Requires that the **SBHP mirror Medicaid to the extent possible within available federal subsidies**. This ensures that low-income residents will have access to a health care package that meets their needs while protecting the state from additional costs for this program.

- **Reduces income eligibility limits for HUSKY A parents** to 133% fpl if the SBHP mirrors Medicaid. Under current Connecticut law, HUSKY A parents are covered in Medicaid up to 185% fpl. If the SBHP offers a program that mirrors Medicaid, HUSKY A parents could be moved to the SBHP with no loss of benefits or increase in cost-sharing and with savings to the state. If HUSKY A parents are moved into an SBHP that does mirror

Medicaid, federal health care reform will result in a loss of coverage for low-income people – clearly not the intent of the federal law.

- **Makes improving provider rates a priority for the use of any surplus SBHP funds or any savings** obtained by changing the income eligibility for HUSKY parents. Increasing provider rates, particularly for specialists, is an important goal and will help to ensure a strong network of providers.

Proposed Drafting Changes:

Attached are proposed changes in the drafted language which will make clearer what I believe to be the intent of the bill. Changed sentences are in italics.

* Adapted from working draft of research paper from the University of Massachusetts Center for Health Law and Economics, March 20, 2012

Proposed Drafting Changes to RB 425

Below are proposed changes in the drafted language which will make clearer what I believe to be the intent of the bill. Changed sentences are in italics.

Section 1(b) – To ensure that the design of the program and the mechanism for creating the design are cost neutral and to ensure that the design is reviewed under the procedures in Sec. 2.

Medical assistance provided through the basic health program shall include the benefits, limits on cost-sharing and other consumer safeguards that apply to medical assistance provided in accordance with Title XIX of the Social Security Act, unless the special advisor determines that the cost of medical assistance provided to enrollees in the basic health program will exceed the federal subsidies available to the state to fund the program. *If the special advisor so determines, the special advisor, in consultation with the commissioner, shall develop and submit a plan, in accordance with section 2 of this act, for the basic health program that maximizes benefits and minimizes cost-sharing, ~~utilizing~~ within funds available from federal subsidies to fund the program. The duties assigned to the special advisor under the provisions of this section shall be implemented within available appropriations. The special advisor is authorized to raise funds from private and public sources outside of the state budget to perform the duties assigned under this section.*

Section 3. To ensure continuation of coverage for HUSKY A children while lowering income eligibility for parents contingent on the adoption of a state BHP that mirrors Medicaid.

Lines 125 - 137:
…an asset limit. *~~On and after January 1, 2014, and contingent upon implementation of a basic health program that includes the same benefits, limits on cost sharing and other consumer safeguards that apply to medical assistance provided in accordance with Title XIX of the Social Security Act, the medical assistance program shall continue to provide coverage to persons under nineteen years of age with family income up to one hundred eighty-five per cent of the federal poverty limit without an asset limit.~~ On and after January 1, 2014, and contingent upon implementation of ~~the~~ a basic health program that includes the same benefits, limits on cost sharing and other consumer safeguards that apply to medical assistance provided in accordance with Title XIX of the Social Security Act,* coverage shall be provided to parents and needy caretaker relatives of persons under nineteen years of age, who qualify for coverage under Section 1931 of the Social Security Act, with family income up to one hundred three-three per cent of the federal poverty level without an asset limit. Such…